DEPARTMENT OF HEALTH AND HUMAN SERVICES

PRINTED: 09/12/2019 FORM APPROVED

CENTER	S FOR MEDICARE &	MEDICAID SERVICES				OMB NC	0. 0938-0391
STATEMENT (DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER;			E CONSTRUCTION 11 - Main Building 01	(X3) DATE COMP	SURVEY
		445234					R
		445234	B. WING			09/	11/2019
NAME OF P	ROVIDER OR SUPPLIER				STREET ADDRESS, CITY, STATE, ZIP CODE		
GLEN OA	KS HEALTH AND REHAE	BILITATION			101 GLEN OAKS ROAD SHELBYVILLE, TN 37160		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE	(X5) COMPLETION DATE
{K 000}	09/11/2019 for all pre- 05/13/2019. All defici	urvey was conducted on vious deficiencies cited on encies have been v non compliance was in compliance with all	{K (000}			

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

PRINTED: 05/16/2019 FORM APPROVED OMB NO. 0938-0391

(X3) DATE SURVEY (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION STATEMENT OF DEFICIENCIES COMPLETED AND PLAN OF CORRECTION IDENTIFICATION NUMBER: A. BUILDING 01 - MAIN BUILDING 01 B. WING 445234 05/13/2019 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 1101 GLEN OAKS ROAD GLEN OAKS HEALTH AND REHABILITATION SHELBYVILLE, TN 37160 PROVIDER'S PLAN OF CORRECTION (X5) COMPLETION DATE SUMMARY STATEMENT OF DEFICIENCIES ID (X4) ID (EACH CORRECTIVE ACTION SHOULD BE (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX PRÉFIX CROSS-REFERENCED TO THE APPROPRIATE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG DEFICIENCY) K 000 K 000 INITIAL COMMENTS Stories: 1 Construction Type: NFPA, V (000); IBC, V unprotected No plans available on site Constructed: 1976 Sprinklered: Yes Census: 54 Certified beds: 130 A Life Safety Code Survey was conducted by the State of Tennessee Department of Health Division of Health Licensure and Regulation Office of Health Care Facilities on 05/13/2019. During this Life Safety Survey, Glen Oaks Health and Rehabilitation was found not in substantial compliance with the requirements for participation in Medicare/Medicaid at 42 CFR Subpart 483,70(a), Life Safety from Fire, and the related National Fire Protection Association (NFPA) standard 101-2012. The requirement at 42 (CFR), Subpart 483.70(a) is NOT MET as evidenced by: K 353 Sprinkler System - Maintenance and Testing K 353 Sprinkler System-Maintenance SS=D CFR(s): NFPA 101 and Testing CFR(s): NFPA 101 SS=D Sprinkler System - Maintenance and Testing Automatic sprinkler and standpipe systems are 1. The company was called to inspected, tested, and maintained in accordance fix repairs on 05/24/19. with NFPA 25, Standard for the Inspection, Testing, and Maintaining of Water-based Fire 2. The antifreeze sprinkler loop Protection Systems. Records of system design. at the canopy will be replaced by maintenance, inspection and testing are maintained in a secure location and readily 06/26/19. 2. The Administrator educated the a) Date sprinkler system last checked maintenance Director and Assistant ITLE continued (X6) DATE LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

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Facility ID: TN0202

CENTE	KS FOR MEDICARE	& MEDICAID SERVICES			MD 140. 0330-0331
	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		LE CONSTRUCTION 6 01 - MAIN BUILDING 01	(X3) DATE SURVEY COMPLETED
		445234	B. WING		05/13/2019
	PROVIDER OR SUPPLIER AKS HEALTH AND RE	HABILITATION		STREET ADDRESS, CITY, STATE, ZIP CODE 1101 GLEN OAKS ROAD SHELBYVILLE, TN 37160	
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K 353	b) Who provided s c) Water system s Provide in REMARI any non-required or system. 9.7.5, 9.7.7, 9.7.8, a This REQUIREMEN by: Based on documer maintain the sprinkl The findings include Document review or report dated 08/22/2 AM, revealed the the canopy needed not provide docume were conducted). N Edition) NFPA 101, 4.1.4.1 (2011 Edition) The Maintenance Dethese deficiencies were conducted to these deficiencies were conducted to these deficiencies were defined and deficiencies were defined and defined a	upply source (S information on coverage for partial automatic sprinkler and NFPA 25 NT is not met as evidenced at review, the facility failed to er system. ed: If the sprinkler inspection 2019 on 05/13/2019 at 11:11 e antifreeze sprinkler loop at replacement (the facility did entation that needed repairs FPA 101, 19.3.5.1 (2012 9.7.5 (2012 Edition) NFPA 25, in) irector was present when were identified and the	K 353	continued 3. The Administrator edul maintenance Director and Maintenance Director on the sprinkler loop at the comonthly. This will be add the TELS program on 05/3. The Maintenance Director will present the TELS repmonthly Quality Assurance Performance Improvement mittee consisting of the ADirector of Nursing, Medi Director, Social Service EPharmacy Representative Control Nurse, Staff Deve Coordinator, Maintenance Medical Records Director 4 months for further follow or recommendations as recommendations as recommendations as recommendations.	checking canopy led to /30/19. cctor ort to ce nt Com- dministrator cal Director, e, Infection elopment e Director times w up and
K 761 SS=D	during the exit confe Maintenance, Inspe CFR(s): NFPA 101	wledged these deficiencies erence on 05/13/2019. ction & Testing - Doors	K 761	Doors CFR(s): NFPA 101	3 Testing
	Fire doors assembli annually in accordant for Fire Doors and C Non-rated doors, inc	ction & Testing - Doors es are inspected and tested nce with NFPA 80, Standard Other Opening Protectives. Cluding corridor doors to moke barrier doors, are as part of the facility		SS=D 1. Corporate Plant and Mand Mand Mand Mand Mand Mand Mand	nce Director 05/30/2019.

	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		FIPLE CONSTRUCTION NG 01 - MAIN BUILDING 01		E SURVEY PLETED
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	PROVIDER OR SUPPLIER AKS HEALTH AND RE	EHABILITATION		STREET ADDRESS, CITY, STATE, ZIP COD 1101 GLEN OAKS ROAD SHELBYVILLE, TN 37160	E	
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K 921 SS=D	maintenance progra Individuals perform testing possess know that demonstrates at Written records of i maintained and are 19.7.6, 8.3.3.1 (LSG 5.2, 5.2.3 (2010 NF This REQUIREMED by: Based on document ensure fire doors as tested annually in a Standard for Fire D Protectives. The findings included Document review o revealed the fire do 2018 did not contain inspection. NFPA 10 NFPA 101, 4.6.12.4 8.3.3.1 (2012 Edition Edition) The Maintenance D these deficiencies of Administrator acknow during the exit confection Electrical Equipment CFR(s): NFPA 101 Electrical Equipment Requirements The physical integric	am. ing the door inspections and byledge, training or experience ability. nspection and testing are available for review. C) FPA 80) NT is not met as evidenced and review, the facility failed to ssemblies are inspected and ccordance with NFPA 80, oors and Other Opening	K 7	2. The Administrator e the Maintenance Direct the Assistant Maintena on inspecting all fire do contain all required point inspection by 05/31/20 3. The Maintenance D present the findings in the Quality Assurance Performer to committe include Administrator, I Nursing, Medical Direct Service Director, Dietar Infection Control Nurse Development Coordinat Maintenance Director, Records Director times for further follow up an recommendations as notes Electrical Equipment-Te Maintenance CFR(s): N SS=D	for and noce Director and not of 19. Irrector will che monthly ormance e. Member Director of for, Social by Manage Staff tor, Medical 4 months d or eeded.	y ers

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		TIPLE CONSTRUCTI NG 01 - MAIN BUIL			SURVEY PLETED
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,	PROVIDER OR SUPPLIER AKS HEALTH AND RE SUMMARY STA	HABILITATION TEMENT OF DEFICIENCIES	ID	1101 GLEN OAK SHELBYVILLE		٧	(X5) COMPLETION
PREFIX TAG	(EACH DEFICIENC)	MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFI) TAG		CORRECTIVE ACTION SHOULD REFERENCED TO THE APPROPE DEFICIENCY)		COMPLETION DATE
K 921	Testing intervals are protocols. All PCRE is tested in accordate before being put into or modification. Any electrical appliance with NFPA 99 as a manuals, instruction by the manufacture required by 10.5.3. development of a pequipment mainten instructions and material material instructions and material material in accordance with the responsible for the of electrical appliant training. 10.3, 10.5.2.1, 10.5.10.5.6, 10.5.8. This REQUIREMENT by: Based on documer facility to comply with and maintenance results and maintenance results.	ned as required in 10.3. The established with policies and the established with policies and the used in patient care rooms not with 10.3.5.4 or 10.3.6 to service and after any repair a system consisting of several system consisting of several system consisting of several system. Service the established are complete system. Service the established are considered in the rogram for electrical equipment intenance manuals are readily albels and condensed the son the appliance are electrical equipment tests, that it is maintained for a monstrate compliance in the facility's policy. Personnel testing, maintenance and use the electrical equipment testing that it is not met as evidenced at review and interview, the shelectrical equipment testing equirements. The difference of the electrical equipment the electrical equipment. NFPA	K 9	1. po te pa ec 2. up fa ab ch by 3. th As Th m ec be ro 4. wi ro fo fo	ontinued The facility will establicies and protocols esting and maintenan atient-care related elequipment by 05/28/20. The Administrator of a letter and send to amily members and report the requirement necking electrical equipment Maintenance Directs and Maintenance Directs and Service Director of Nursing sure all electrical equipment has been to be proposed to a residence of the Director of Nursing sure all electrical equipment has been to be proposed to a residence of the Maintenance Director of Nursing sure all electrical equipment has been to be proposed to a residence of the Maintenance Director of Nursing sure all electrical equipment has been to be proposed to a residence of the Maintenance Director of Nursing and the Maintenance Director of Nursin	for the ce of ectrical of 19. will type of all esident for uipment educated for and gon cal ested idents Director ent ly time of tim	e t ed tor,

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '	IPLE CONSTRUCTION IG 01 - MAIN BUILDING 01		E SURVEY IPLETED
		445234	B. WING_		05/	13/2019
	PROVIDER OR SUPPLIEF		STREET ADDRESS, CITY, STATE, ZIP CODE 1101 GLEN OAKS ROAD SHELBYVILLE, TN 37160			
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K 921	The Maintenance these deficiencies Administrator ackr	age 4 Director was present when were identified and the nowledged these deficiencies iference on 05/13/2019.	K 92	The Maintenance Direct present findings to the Control Assurance Performance Committee. Members in Administrator, Director of Social Service Director, Manager, Pharmacy Result Infection Control Nurse, Records Director, Medical Maintenance Director times four months for further follow up and or recommendations as necessarily as necessa	Quality e Improver nclude of Nursing Dietary epresentati , Medical cal Directo	ive

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{E 000}	conducted on 09/11/2 deficiencies cited on 0 have been corrected, was found. The facilit regulations surveyed.	edness revisit survey was 019 for all previous 05/13/2019. All deficiencies and no new noncompliance by is in compliance with all	{E 00/			(X6) DATE

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		445234	B, WING			05/13/2019	
	PROVIDER OR SUPPLIER AKS HEALTH AND RE	EHABILITATION	ß	110	REET ADDRESS, CITY, STATE, ZIP CODE 01 GLEN OAKS ROAD HELBYVILLE, TN 37160		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETION DATE
E 000	Initial Comments A Emergency Preponducted by the Stoff Health Division on Regulation Office of on 05/13/2019. Dur Preparedness Survente Rehabilitation was recompliance with the in Emergency Preparedness Preparedness Care Factors. The requirement at MET as evidenced I Plan Based on All H CFR(s): 483.73(a)(1) [(a) Emergency Plan and maintain an emithat must be review annually. The plan refacility-based and coassessment, utilizing for LTC facilities and and include a docommunity-based ri	paredness Survey was tate of Tennessee Department of Health Licensure and of Health Care Facilities survey ing this Emergency ey, Glen Oaks Health and not found in substantial erequirements for participation aredness Regulations for incilities, Federal CFR §483.73. 42 CFR, §483.73 are NOT by: Ilazards Risk Assessment (1)-(2) In. The [facility] must develop be gency preparedness planed, and updated at least must do the following:] If include a documented, community-based risk gan all-hazards approach.* Int §483.73(a)(1):] (1) Be based cumented, facility-based and sk assessment, utilizing an	EO	000	Plan Based on All Hazards Assessment CFR(s): 483(a SS=D 1. The facility had a round meeting/safety meeting on regarding facility emergency preparedness program. 2. Facility round table com addressed the community and facility based assessm will update risk assessment)(1)-(2) table 05/28/2 y mittee ents an	
	*[For ICF/IIDs at §48 and include a docum community-based riall-hazards approach (2) Include strategic	h, including missing residents. 33.475(a)(1):] (1) Be based on nented, facility-based and sk assessment, utilizing an h, including missing clients.			05/30/19. 3. Administrator educated round table committee on 0 regarding risk hazards.	the 5/28/20	119
ABORATORY	DIRECTOR'S OR PROVIDE	R/SUPPLIER REPRESENTATIVE'S SIGN	ATURE		TITLE	.1	(X6) DATE

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E 006	* [For Hospices at § strategies for addresidentified by the rishmanagement of the failures, natural distributes and affect the care. This REQUIREMENT by: Based on interview complete the risk and all-hazards approached approached and the complete the risk and all-hazards approached and the finding included interview on 05/13/2 facility's facility base assessment for the program did not util	the risk assessment. §418.113(a)(2):] (2) Include essing emergency events assessment, including the econsequences of power easters, and other emergencies hospice's ability to provide. It is not met as evidenced as, the facility failed to essessment utilizing an entire per the requirements of 73.	EO	continued 4. Administrator will bring round table committee safe emergency preparedness to monthly Quality Assurar Performance Improvement which consist of Administration Director of Nursing, Medical Social Service Director, Machine Director, Infection Control Staff Development Coordination Medical Records Coordination monthly times 4 months for follow up and or recommendation as needed.	ety/ notes nce t committee ator, al Director, aintenance Nurse, nator itor r further	
	during the interview preparedness progress Subsistence Needs CFR(s): 483.73(b)(for policies and prodevelop and implementation policies and proceed plan set forth in parassessment at para and the communications.	for Staff and Patients	ΕO	Subsistence Needs for Star Patients CFR(s) 483.73(b) SS=D 1. Facility had a round tab committee meeting on 05/2 to discuss emergency preparation.	(1) le/safety 28/2019 paredness	

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		445234	B. WING	_		05/	13/2019
	PROVIDER OR SUPPLIER AKS HEALTH AND RE	HABILITATION		1	STREET ADDRESS, CITY, STATE, ZIP CODE 1101 GLEN OAKS ROAD SHELBYVILLE, TN 37160		
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	minimum, the polici address the followin (1) The provision of and patients whether place, include, but a (i) Food, water, med supplies (ii) Alternate source following: (A) Temperatures safety and for the saprovisions. (B) Emergency lig (C) Fire detection systems. (D) Sewage and water in The policies and proced (6) The following are hospice-operated in The policies and proced (6) The policies and proced (6) The policies and proced (6) The provision of hospice employees evacuate or shelter limited to the following: (A) Food, water, resupplies. (B) Alternate sour following: (1) Temperature and safety and for the provisions. (2) Emergency	ed at least annually.] At a es and procedures must es and procedures must es and procedures must est they evacuate or shelter in the not limited to the following: dical and pharmaceutical is of energy to maintain the sto protect patient health and afe and sanitary storage of enting. In extinguishing, and alarm waste disposal. Indice at §418.113(b)(6)(iii):] ures. In additional requirements for patient care facilities only. In execution in the est of energy to maintain the est of energy to maintain the est of energy to maintain the est of protect patient health is eafe and sanitary storage	EC)15	continued 2. The facility round table mittee addressed the substanceds for staff and patient 05/28/2019. 3. The Dietary Manager veducated on 05/28/2019 reproviding food and water is emergency situation for 75 and 50 staff members. 4. Dietary Manager will purply plan to monthly Quality As Performance Improvement Committee which includes Administrator, Medical Director of Nursing, Social Director, Director of Rehall Infection Control Nurse, Social Director Contro	sistence ts on vas egardir n an 5 reside resent ssurance tt s ector, I Service bilitation taff , Medic thly follow	ents e e e

	FOF DEFICIENCIES OF CORRECTION			(X3) DATE SURVEY COMPLETED		
		445234	B. WING		05/13/2019	
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	This REQUIREME by: Based on docume facility failed to income for the subsistence the emergency present at 1:45 PM, the fact and procedures for needs for staff and evacuate or shelter limited to the following. Food, water, most supplies This finding was veduring the interview preparedness progressive for Evac. at CFR(s): 483.73(b)(fight) Policies and procedures an	It waste disposal. Interview and interviews, the lude all policies and procedures aneeds of residents and staff in a paredness program. Ided: Interviews on 05/13/2019 Ided: Ided: Interviews on 05/13/2019 Ided: Ided:	E 015		ble/	

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E 020	consideration of caevacuees; staff residentification of evaprimary and alternation with external source *[For RNHCs at §4 §416.54(b)(2):] Safe evacuation frincludes the followi (i) Consideration of (ii) Staff responsibilitient (iii) Transportation. (iv) Identification of (v) Primary and altocommunication with assistance. * [For CORFs at §4 Rehabilitation Ager §485.727(b)(1), ans §494.62(b)(2):] Safe evacuation from Rehabilitation Ager Agencies as Provice Therapy and Speed Services; and ESR staff responsibilities and This REQUIREMEI by: Based on docume facility failed to include the succession of the safe of t	om the [facility], which includes are and treatment needs of sponsibilities; transportation; acuation location(s); and ate means of communication ses of assistance. 03.748(b)(3) and ASCs at om the [RNHCl or ASC] which ing: f care needs of evacuees. lities.	E 02	Continued 2. Facility round table commaddressed the evacuation of residents, and visitors. 3. The round table committed started addressing the evacuation on 05/28/2019. 4. The Administrator will present to the Quality Assurance Pelemprovement Committee who consist of Administrator, Medical Record Coordinator, Medical Record Coordinator, Medical Record Coordinator, Maintenance Demonthly times 4 months for the follow up and or recommendation as needed.	lan for staff ee uation histrator formar dical lopmer dis former further lations	nce	

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E 020	Continued From pa preparedness progr The finding included	ram.	E 020			
	Document review a 1:50 PM, revealed t	nd interviewson 05/13/2019 at he facility had not developed ures for the evacutation of the				
during the interview preparedness prog E 022 Policies/Procedure CFR(s): 483.73(b)(s for Sheltering in Place 4)	E 022	in Place CFR(s): 483.73(b)(4	-	
	develop and implem policies and proced plan set forth in para assessment at para and the communica this section. The po reviewed and updat	ncedures. The [facilities] must nent emergency preparedness ures, based on the emergency agraph (a) of this section, risk graph (a)(1) of this section, tion plan at paragraph (c) of licies and procedures must be ed at least annually. At a es and procedures must g:]		SS=D 1. The facility had a round to meeting/safety committee m on 05/28/2019 regarding facemergency preparedness program. 2. Facility round table commaddressed the policy and	eeting ility	
	and volunteers who (2),(3),(5),(6)] A mean patients, staff, and very [facility]. *[For Inpatient Hosp and procedures.	ter in place for patients, staff, remain in the [facility]. [(4) or ans to shelter in place for volunteers who remain in the pices at §418.113(b):] Policies additional requirements for		procedure on sheltering residual staff and visitors. 3. The policy and procedure evacuation will be educated round table committee members continued.	for by a per	

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		445234	B WING _		05/13/2019	
NAME OF PROVIDER OR SUPPLIER GLEN OAKS HEALTH AND REHABILITATION (X4) ID SUMMARY STATEMENT OF DEFICIENCIES (FACH DEFICIENCY MUST BE REFERED BY FULL)			STREET ADDRESS, CITY, STATE, ZIP CODE 1101 GLEN OAKS ROAD SHELBYVILLE, TN 37160			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIC (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROF DEFICIENCY)	D BE COMPLETION	
E 022	The policies and price following: (i) A means to she hospice employees This REQUIREMENT by: Based on document facility falled to inclusion for sheltering in plan preparedness programment facility falled to include the finding included Document review a 1:55 PM, revealed to the following for the finding included the findin	npatient care facilities only. ocedures must address the nelter in place for patients, who remain in the hospice. NT is not met as evidenced nt review and interviews, the ude policies and procedures ce in the emergency ram. d: nd interviewson 05/13/2019 at the facility had not developed ures for sheltering the	E 02	continued starting 05/29/19 and to be o by 06/27/2019. 4. The Administrator will pre to the monthly Quality Assur Performance Improvement of which consist of Administrat Medical Director, Director of Social Service Director, Main Director, Infection Control N Staff Development Coordina Medical Records Director m times 4 months for further for and or recommendations as	esent rance committee or, Nursing, ntenance urse, utor, onthly	
	during the interview preparedness progress Procedures CFR(s): 483.73(b)(6 [(b) Policies and prodevelop and implementation of the policies and procedures plan set forth in para assessment at para and the communication this section. The poreviewed and updated	s-Volunteers and Staffing becedures. The [facilities] must ment emergency preparedness ures, based on the emergency agraph (a) of this section, risk graph (a)(1) of this section, tion plan at paragraph (c) of licies and procedures must be ed at least annually. At a less and procedures must	E 024	Policies/Procedures-Volunte Staffing CFR(s): 483.73(b)(6 SS=D 1. The facility had a round t meeting/safety committee m on 05/28/2019 regarding fac emergency preparedness procedures	able neeting cility rogram	

	FOF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL A. BUILD		E CONSTRUCTION		E SURVEY PLETED
		445234	B. WING			05/	13/2019
	PROVIDER OR SUPPLIER AKS HEALTH AND RE	HABILITATION		110	REET ADDRESS, CITY, STATE, ZIP CODE 01 GLEN OAKS ROAD HELBYVILLE, TN 37160		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
E 024	volunteers in an em staffing strategies, ifor integration of Stahealth care profess during an emergency and emergency and othe strategies to address emergency. *[For Hospice at §4 procedures. (4) The an emergency and strategies, including integration of State health care profess needs during an em This REQUIREMEN by: Based on interview policies and proced in the emergency prequirements of Fed The finding included Interview on 05/13/2 facility had no reconfor the use of volunt other emergency staprocess and role for Federally designate address surge needs	as noted above] The use of hergency or other emergency including the process and role ate and Federally designated ionals to address surge needs cy. 3.748(b):] Policies and e use of volunteers in an er emergency staffing as surge needs during an ate use of hospice employees in other emergency staffing the process and role for and Federally designated sionals to address surge needs of hergency. T is not met as evidenced the facility failed to include ures for the use of volunteers reparedness program per the deral CFR §483.73.	EO	024	Continued 2. Facility round table comaddressed the use of volunduring an emergency and estaff that are not working we emergency occurs. 3. The facility will reach outlocal county Emergency M Service for assistance with in touch with county volunt case of emergency by 05/34. The facility will update is emergency preparedness with information as it come the facility. 5. The Administrator will provement committee we includes, Administrator, Dis Nursing, Medical Director, Service Director, Maintena Director, Infection Control Medical Records Director, Development Director montimes 4 months for further up and or recommendation needed.	nteers utilizing when an ut to the anager getting eers in 30/19. ts manual es to resent Perform hich rector of Social nce Nurse, Staff othly follow	ment

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT A. BUILDIN	IPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	445234	B. WING		05/13/2019
NAME OF PROVIDER OR SUPPLIER GLEN OAKS HEALTH AND REF	HABILITATION		STREET ADDRESS, CITY, STATE, ZIP CODE 1101 GLEN OAKS ROAD SHELBYVILLE, TN 37160	
PREFIX (EACH DEFICIENCY I	EMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL C IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE COMPLETION
preparedness prograted Arrangement with Oth CFR(s): 483.73(b)(7) [(b) Policies and procedured policies and procedured plan set forth in paragasessment at paragand the communication this section. The policies address the following: *[For Hospices at §4*§441.184,(b) Hospital Facilities at §483.73((7) [or (5)] The developments in the event operations to maintain to facility patients. *[For PACE at §460.8§483.475(b), CAHs at §485.920(b) and ESF Policies and procedured development of arrant [facilities] [or] other procedures in the event of limitation operations to maintain to facility patients. *[For RNHCIs at §400 procedures. (7) The control of the event of limitation operations to maintain to facility patients.	the facility's emergency am ther Facilities cedures. The [facilities] must ent emergency preparedness res, based on the emergency graph (a) of this section, risk raph (a)(1) of this section, ion plan at paragraph (c) of cies and procedures must be d at least annually. At a s and procedures must s:] 18.113(b), PRFTs at als at §482.15(b), and LTC b):] Policies and procedures. opment of arrangements with other providers to receive of limitations or cessation of an the continuity of services 84(b), ICF/IIDs at at §486.625(b), CMHCs at RD Facilities at §494.62(b):] res. (7) [or (6), (8)] The agements with other roviders to receive patients ions or cessation of an the continuity of services	E 02		d table meeting nmittee procedure nts event s/19. ittee poiders s/27/19. present Performance which fledical ng, Staff intenance irector, nes 4 p and or

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, ,	IPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		445234	B. WING		05/13/2019
	PROVIDER OR SUPPLIER AKS HEALTH AND RE	EHABILITATION		STREET ADDRESS, CITY, STATE, ZIP CODE 1101 GLEN OAKS ROAD SHELBYVILLE, TN 37160	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE COMPLETION
E 025	providers to receive patients in the event of limitations or cessation of operations to maintain the continuity of non-medical services to RNHCl patients. This REQUIREMENT is not met as evidenced by: Based on document review and interview, the facility failed to develop arrangements with other facilities receive patients in the event of limitations or cessation of operations to maintain the continuity of services to facility patients. The finding included: Document review and interview on 05/13/2019 at 2:07 PM, the facility did not provide written		E 02	25	
SS=D	patients in the even operations to maint to facility patients This finding was verduring the interview preparedness programmes and Contact CFR(s): 483.73(c)(for the facility) multiple emergency prepare that complies with Fand must be review annually. The commall of the following: (1) Names and contact following: (i) Staff.	t Information	E 03	Names and Contact Inform CFR(s): 483.73(c)(1) SS=D 1. The facility had a round meeting/safety committee on 05/28/2019. 2. Facility round table com addressed having names a contact information for staff Contine	table meeting amittee and f

	OF CORRECTION	IDENTIFICATION NUMBER:	A BUILD		E CONSTRUCTION		PLETED
		445234	B. WING			05/	13/2019
	PROVIDER OR SUPPLIER			11	TREET ADDRESS, CITY, STATE, ZIP CODE 101 GLEN OAKS ROAD HELBYVILLE, TN 37160		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	x	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	BE	(X5) COMPLETION DATE
	following: (1) Names and confollowing: (i) Staff. (ii) Entities providin (iii) Next of kin, gua (iv) Other RNHCIs. (v) Volunteers. *[For ASCs at §416 plan must include at (1) Names and confollowing: (i) Staff. (ii) Entities providing (iii) Patients' physic (iv) Volunteers. *[For Hospices at § communication plan following: (1) Names and confollowing: (1) Names and confollowing: (1) Names and confollowing: (1) Hospice employed (ii) Entities providing (iii) Patients' physic (iv) Other hospices. *[For HHAs at §484 plan must include a	sians []. []. []. []. []. []. []. []	EO	930	Continued and entities with service agree patient's physicians, Next of guardian or custodian, other and volunteers. 3. The round table committee will work on getting written agreements with other provide and have completed by 06/27. 4. The Administrator will prest to the Quality Assurance Per Improvement committee whice consist of Administrator, Medical Records Director, St. Development Director, Mainted Director. Social Service Director Infection Control Nurse times months for further follow up a recommendations as needed.	kin, facilitie e lers 7/19. sent forman ch lical aff enance ctor, 6.4	es

T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED	
	445234	B. WING	-	05/13/2019	
NAME OF PROVIDER OR SUPPLIER GLEN OAKS HEALTH AND REHABILITATION (X4) ID SUMMARY STATEMENT OF DEFICIENCIES			101 GLEN OAKS ROAD		
(EACH DEFICIENCY	MUST BE PRECEDED BY FULL	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE COMPLÉTION	
(i) Staff. (ii) Entities providing (iii) Patients' physici (iv) Volunteers. *[For OPOs at §486 plan must include a (1) Names and confollowing: (i) Staff. (ii) Entities providing (iii) Volunteers. (iv) Other OPOs. (v) Transplant and continuity of the Continuity of	g services under arrangement. ians. i.360(c):] The communication If of the following: tact information for the g services under arrangement. Idonor hospitals in the OPO's rea (DSA). IT is not met as evidenced at review, the facility failed to cation plan that includes	E 030			
Document review or revealed the facility information for Entit arrangement. This finding was ver during the interview preparedness progr LTC and ICF/IID Sh. CFR(s): 483.73(c)(8) [(c) The [LTC facility and maintain an em communication plan	in 05/13/2019 at 2:13 PM, did nto have contact lies providing services under diffied by the administrator of the facility's emergency am aring Plan with Patients and ICF/IID] must develop ergency preparedness that complies with Federal,	E 035	LTC and ICF/IID Sharing Plane Patients CFR(s): 483.73(c)(8 SS=D 1. The facility had a round take meeting/safety committee meeting/safety committe) ble	
	PROVIDER OR SUPPLIER AKS HEALTH AND RE SUMMARY STA (EACH DEFICIENCY REGULATORY OR LE Continued From pa (i) Staff. (ii) Entities providing (iii) Patients' physici (iv) Volunteers. *[For OPOs at §486 plan must include a (1) Names and conf following: (i) Staff. (ii) Entities providing (iii) Volunteers. (iv) Other OPOs. (v) Transplant and of Donation Service Ar This REQUIREMEN by: Based on document develop a communic contact information. The findings include Document review or revealed the facility information for Entity arrangement. This finding was ver during the interview preparedness progr. LTC and ICF/IID Sho CFR(s): 483.73(c)(8) [(c) The [LTC facility and maintain an em communication plan	PROVIDER OR SUPPLIER AKS HEALTH AND REHABILITATION SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) Continued From page 11 (i) Staff. (ii) Entities providing services under arrangement. (iii) Patients' physicians. (iv) Volunteers. *[For OPOs at §486.360(c):] The communication plan must include all of the following: (1) Names and contact information for the following: (i) Staff. (ii) Entities providing services under arrangement. (iii) Volunteers. (iv) Other OPOs. (v) Transplant and donor hospitals in the OPO's Donation Service Area (DSA). This REQUIREMENT is not met as evidenced by: Based on document review, the facility failed to develop a communication plan that includes contact information. The findings included: Document review on 05/13/2019 at 2:13 PM, revealed the facility did nto have contact information for Entities providing services under	PROVIDER OR SUPPLIER AKS HEALTH AND REHABILITATION SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) Continued From page 11 (i) Staff. (ii) Entities providing services under arrangement. (iii) Patients' physicians. (iv) Volunteers. *[For OPOs at §486.360(c):] The communication plan must include all of the following: (i) Staff. (ii) Entities providing services under arrangement. (iii) Polunteers. (iv) Other OPOs. (v) Transplant and donor hospitals in the OPO's Donation Service Area (DSA). This REQUIREMENT is not met as evidenced by: Based on document review, the facility failed to develop a communication plan that includes contact information. The findings included: Document review on 05/13/2019 at 2:13 PM, revealed the facility did nto have contact information for Entities providing services under arrangement. This finding was verified by the administrator during the interview of the facility's emergency preparedness program. LTC and ICF/IID Sharing Plan with Patients CFR(s): 483.73(c)(8) [(c) The [LTC facility and ICF/IID] must develop and maintain an emergency preparedness communication plan that complies with Federal,	PROVIDER OR SUPPLIER AKS HEALTH AND REHABILITATION SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FILL REGULATORY OR LSC IDENTIFYING INFORMATION) Continued From page 11 (i) Staff. (ii) Entities providing services under arrangement. (iii) Patients' physicians. (iv) Volunteers. (iv) Volunteers. (iv) Other OPOs at §488.360(c):] The communication plan must include all of the following: (ii) Staff. (iii) Entities providing services under arrangement. (iii) Volunteers. (iv) Transplant and donor hospitals in the OPO's Donation Service Area (DSA). This REQUIREMENT is not met as evidenced by: Based on document review, the facility failed to develop a communication plan that includes contact information for Entities providing services under arrangement. This finding was verified by the administrator during the interview of the facility's emergency preparedness program. LTC and ICF/IID Sharing Plan with Patients CFR(s): 483.73(c)(8) [(c) The [LTC facility and ICF/IID] must develop and maintain an emergency preparedness communication plan that complies with Federal,	

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	A. BUILDIN	TIPLE CONSTRUCTION (X3) DATE SUR COMPLETE	
		445234	B. WING _		05/13/2019
	PROVIDER OR SUPPLIER AKS HEALTH AND RE	HABILITATION		STREET ADDRESS, CITY, STATE, ZIP CODE 1101 GLEN OAKS ROAD SHELBYVILLE, TN 37160	,
(X4) ID PREFIX TAG	FIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE COMPLETION
E 036 SS=D	(8) A method for sha emergency plan, that is appropriate, with a families or represent This REQUIREMEN by: Based on document facility failed to devet that includes a meth preparedness plan to representatives per The findings included Document review ar 2:20 PM, revealed the methods and proceed from the emergency families or represent This finding was ver during the interview preparedness prograted EP Training and Test CFR(s): 483.73(d) (d) Training and test develop and maintai preparedness training based on the emerging paragraph (a) of this paragraph (a) of this paragraph (a) (1) of the procedures at paragethe communication paragraph the communication paragraph (a) the	nually.] The communication aring information from the set the facility has determined residents [or clients] and their tatives. It is not met as evidenced at review and interview, the elop a communication plan and for sharing the emergency to residents, families and CFR 483.73 (c). Indicate the facility failed to provide the facility failed to provide the plan with residents and their tatives. If	E 03	Continued on 05/28/2019. 2. The Administrator will writ a communication plan for resumed and their family representative by 06/27/2019. 3. The Administrator will write a communication plan for the admission packet for future resumed by 06/27/2019. 4. The Administrator will present to the Quality Assurance Persumprovement committee which of Administrator, Medical Director of Nursing, Social Socia	e up esidents sent formance ch consist ector, ervice erse, Develop ecords bllow up eded. 06/27/19 table on ommittee
				continue	d

DEPARTMENT OF HEALTH AND HUMAN SERVICES

CENTERS FOR MEDICARE & MEDICAID SERVICES

NAME OF PROVIDER OR SUPPLIER GLEN OAKS HEALTH AND REHABILITATION SUMMARY STATEMENT OF DEFICIENCIES (EACH DEPTICINCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) E 036 Continued From page 13 be reviewed and updated at least annually. "[For ICF/IID must develop and maintain an emergency preparedness training and testing program that is based on the emergency plan set forth in paragraph (a) (1) of this section, policies and procedures at paragraph (b) of this section, risk assessment at paragraph (a) of this section, policies and procedures at paragraph (b) of this section, risk assessment at paragraph (a) of this section, policies and procedures at paragraph (b) of this section, risk assessment at paragraph (b) of this section, risk assessment at paragraph (b) of this section, risk assessment at paragraph (b) of this section, policies and procedures at paragraph (b) of this section, policies and procedure		OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL A. BUILD		LE CONSTRUCTION		PLETED
Interest Name of the State of			445234	B. WING			05/	13/2019
E 036 Continued From page 13 be reviewed and updated at least annually. *[For ICF/IIDs at \$483.475(d):] Training and testing program that is based on the emergency plan at paragraph (a) of this section, and the communication plan at paragraph (c) of this section, and the communication plan at least annually. *[For ESRD Facilities at \$494.62(d):] Training, testing, and orientation. The dialysis facility must develop and maintain an emergency preparedness training, and testing program must be reviewed and updated at least annually. This REQUIREMENT is not met as evidenced by: Based on interview, the facility failed to include develop and maintain an emergency preparedness training and testing program must be reviewed and updated at least annually. This REQUIREMENT is not met as evidenced by: Based on interview, the facility failed to include develop and maintain an emergency preparedness training and testing program that is based on the emergency preparedness training and testing program that is based on the emergency preparedness training, testing and patient orientation program that is based on the emergency preparedness training and testing program that is based on the emergency preparedness training and testing program that is based on the emergency preparedness training and testing program that is based on the emergency preparedness training and testing program that is based on the emergency preparedness training and testing program that is based on the emergency preparedness training and testing program that is based on the emergency preparedness training and testing program that is based on the emergency preparedness training and testing program that is based on the emergency preparedness program per the requirements of Federal CFR \$483.73.	GLEN O	AKS HEALTH AND RE		(5)	1	101 GLEN OAKS ROAD SHELBYVILLE, TN 37160	N	(VE)
E 036 Continued From page 13 be reviewed and updated at least annually. *[For ICF/IIDs at \$483.475(d):] Training and testing. The ICF/IID must develop and maintain an emergency preparedness training and testing program that is based on the emergency plan set forth in paragraph (a) of this section, policies and procedures a paragraph (b) of this section, and the communication plan at paragraph (c) of this section. The training and testing program must be reviewed and updated at least annually. The ICF/IID must meet the requirements for evacuation drills and training by 06/27/2019. 3. The round table committee members will educate staff by 06/11/2019. 4. The Administrator will present the results to the Quality Assurance Performance Improvement Committee which includes the Administrator, Director of Nursing, Medical Director, Infection Control Nurse, Social Service Director, Medical Records Director, Staff Development Director, Maintenance Director and Rehab Director and floor staff times four months for further follow up and or recommendations as needed. **Pof SSRD Facilities at \$494.62(d):] Training, testing, and orientation, The dialysis facility must develop and maintain an emergency preparedness training, testing and patient orientation program that is based on the emergency plan set forth in paragraph (a) of this section, policies and procedures at paragraph (b) of this section, and the communication plan at paragraph (c) of this section. The dialysis facility must develop and maintain an emergency preparedness training and testing program that the requirements for evacuation drills and training by 06/27/2019. **The staff will participate in our drill and training by 06/27/2019. **The Administrator will present the results to the Quality Assurance Performance Improvement Committee which includes the Administrator, Director, Staff Development Director, Maintenance Director and floor staff times four months for further follow up and or recommendations as needed. **Pof Maintenance Director and Rehab Dir	PREFIX	(EACH DEFICIENCY	MUST BE PRECEDED BY FULL	PREFI		(EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP	BE	
The initiality interaction	E 036	*[For ICF/IIDs at §4 testing. The ICF/IID an emergency prep program that is bas forth in paragraph (a assessment at para policies and proced section, and the corparagraph (c) of this testing program mu least annually. The requirements for ev. §483.470(h). *[For ESRD Facilities testing, and orientation program emergency plan set section, risk assess this section, policies (b) of this section, a paragraph (c) of this and orientation program emergency plan set section, risk assess this section, policies (b) of this section, a paragraph (c) of this and orientation progrupdated at least and This REQUIREMEN by: Based on interview develop and mainta preparedness training based on the emergency preparedness progr	dated at least annually. 83.475(d):] Training and must develop and maintain aredness training and testing ed on the emergency plan set a) of this section, risk graph (a)(1) of this section, ures at paragraph (b) of this munication plan at a section. The training and set be reviewed and updated at ICF/IID must meet the acuation drills and training at a set §494.62(d):] Training, sion. The dialysis facility must in an emergency and patient that is based on the forth in paragraph (a)(1) of and procedures at paragraph as section. The training, testing from must be reviewed and an ally. It is not met as evidenced the facility failed to include in an emergency and and testing program that is lency plan in the emergency am per the requirements of 73.	EC	036	and testing and will meet the requirements for evacuation drills and training by 06/27/2 2. The staff will participate is drill and training by 06/27/2 3. The round table committed members will educate staff to 06/11/2019. 4. The Administrator will present the results to the Quality Assembler Performance Improvement of Which includes the Administration Director of Nursing, Medical Infection Control Nurse, Social Service Director, Medical Red Director, Staff Development Maintenance Director and Red and floor staff times four more for further follow up and or	2019. In our 1019.	or, or, oirector

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				DATE SURVEY COMPLETED	
		445234	B. WING	_		05/	13/2019
	PROVIDER OR SUPPLIER AKS HEALTH AND RE	HABILITATION		1	TREET ADDRESS, CITY, STATE, ZIP CODE 101 GLEN OAKS ROAD SHELBYVILLE, TN 37160		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES ' MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	BE !	(X5) COMPLETION DATE
E 036	Interview on 05/13/2 facility had no recor for the training and on the emergency preparedness programmers. This finding was ve	2019 at 2:30 PM, revealed the d of polices and procedures testing program that is based plan in the emergency ram.	E	036			